Arizona Department of Administration
Benefit Services Division

Older Child Enrollment Forms and Instructions

The documents contained herein are to assist employees and retirees enrolling an Older Child.

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Older Child Certification Instructions

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Adding an Older Child

To add an older child:

■ Complete and return the form(s) in this packet. You must complete a separate form for each child you are adding.

Step One (Tax Treatment):

■ Review the *Declaration of Tax Status* to determine whether your Older Child fulfills the requirements to be a tax dependent.
Your older child does not need to qualify as a tax dependent to qualify for insurance coverage, however if your older child does not qualify as a tax dependent, you may be taxed on any additional employer's contribution toward coverage.

■ If you are unsure whether your older child meets the support requirement for dependent status, you may confirm eligibility by using the optional *Worksheet for Determining Support* form.

- ■ If completing the optional *Worksheet for Determining Support*, you will need to know your older child's
  - ▪ Gross monthly income, if any
  - ▪ Mortgage/ rental payment, if any
  - ▪ Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- ■ Keep the worksheet for your personal records. You do not need to return the worksheet with the other forms.

■ Sign, date, and print your Employee ID Number (EIN) on the *Declaration of Tax Status* form.

Step Two:

■ Return the forms (excluding the Worksheet) to:
State of Arizona Department of Administration, Benefit Services Division
100 N. 15th Ave. Suite 103, Phoenix, AZ, 85007

Important:
Be sure to also submit a completed enrollment form.

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Do **not** return this form; keep for your own records.

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Older Child Declaration of Tax Status

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You must complete a separate form for each child you are adding.

I, _____, declare

_____ as my Older Child.
Print Name of Older Child

I understand that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that an older child is considered a tax dependent for purposes of employer provided health plans **only if** each of the following requirements are met:

1. My older child is **NOT** my qualifying child as defined by IRC 152(c), or the qualifying child (dependent) of another taxpayer.
Generally, to be a qualifying child under IRC 152(c) and also meet plan coverage eligibility, the child must:
A.) Be your son, daughter, stepchild, foster child; AND
B.) Be under age 19 at the end of the year, OR
Be under age 24 at the end of the year and a full-time student, OR
Be any age and permanently and totally disabled.
C.) Have lived with you for more than half of the year.

AND

2. My older child is related to me in one of the following ways:
A.) My child, stepchild, foster child, or adopted child.

AND

3. My older child receives more than half of his or her support from me.
Enclosed is a Worksheet for Determining Support, similar to the one the Internal Revenue Service (IRS) includes in its Publication 17, that you can use to determine whether you provide, or expect to provide, more than half of your older child's support.

AND

4. My older child child is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico, for some part of the year.

Check one of the following boxes. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances.

Based on the criteria above, I declare that:
□ **Yes**, my older child is reasonably expected to be my tax dependent for the 20___ calendar year.

□ **No**, my older child is not expected to be my tax dependent for the year 20___ calendar year.
As a result, premium contributions for my older child cannot be taken on a pre-tax basis and the value of the benefits my employer provides for my older child may be added to my taxable income.

By signing this form:
I declare that the information I have provided is true, complete, and correct. If it is not, or if I do not update this information within the timelines stated in the benefit rules, I may be liable for any claims paid by my health plan(s) or premiums paid on my behalf and my older child's behalf.
I understand that:
- This declaration of tax status may have legal implications under federal and/or state law.
- A civil action may be brought against me for any losses, including reasonable attorney's fees, if I have made a false statement in this declaration.
- I must notify my benefits office if there is a change in the tax status of my older child within 31 days of the change. A change in my family status may directly impact the calculation of my taxable income.

Subscriber's Signature	EIN	Date

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Worksheet for Determining Support

This worksheet is modeled after the Internal Revenue Service Publication 17 worksheet and requests historical information. However, it is necessary that you determine whether your domestic partner, older child, or domestic partner's child, will qualify as a dependent for the calendar year the dependent is enrolling (the "enrollment year"). Complete this worksheet using the income and expenses you anticipate during the enrollment year to determine if you provide more than one-half of the support for your domestic partner, older child, or domestic partner's child. A separate worksheet must be completed for each individual.

Important:
You can use this worksheet to determine whether an individual meets the support test to qualify as a tax dependent.

Individual's Income

1. Did the individiual you supported receive any income, such as wages, interest dividends, pensions, rents, social security, or welfare?
   □ Yes (Answer questions 2, 3, 4, and 5.)
   □ No (Skip to question 6.)
2. Total annual income received $ _____
3. Amount of income used for the individual's support $ _____
4. Amount of income used for purposes other than support $ _____
5. Amount of income either saved or not used for lines 3 or 4 $ _____

The total of lines 3, 4, and 5 should equal line 2.

Yearly household expenses where you and the individual live

6. Lodging *(Complete either a or b):*
   a. Rent Paid $ _____
   b. If not rented, show fair rental value of your home. If your domestic partner owned the home, include this amount on line 21. $ _____
7. Food $ _____
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) $ _____
9. Repairs that were not included in line 6a or 6b $ _____
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). $ _____
11. Add lines 6a or 6b through 10 $ _____
12. Total number of persons who lived in the household $ _____

Yearly expenses for the individual

13. Divide line 11 by line 12 to determine each person's part of household expenses
    $ _____ (line 11) ÷ _____ (line 12) = $ _____
14. Clothing $ _____
15. Education $ _____
16. Medical and dental $ _____
17. Travel and recreation $ _____
18. Other (please specify) _____ $ _____
    _____ $ _____
    _____ $ _____
19. Total amount for the individual's yearly support (Add lines 13 through 18.) $ _____
20. Multiply line 19 by 50% (.50) $ _____
21. Amount the individual provided for his or her own support
    Line 3 $ _____
    Line 6b (include if the individual owned the home) $ _____
    Add lines 3 and 6b, if each are applicable $ _____
22. Amount that others added to the individual's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts from line 2. $ _____
23. Amount you provided for the individual's support:
    $_____ (line 19) - $_____ (line 21) - $_____ (line 22) = $ _____
24. Is line 23 more than line 20? If so, the individual qualifies as a tax dependent.

Check "Yes" on the *appropriate Declaration of Tax Status* form.

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STATE OF ARIZONA ACTIVE OPEN ENROLLMENT 2008-2009

AGENCY CODE	AGENCY	DATE RECEIVED

DO NOT WRITE ABOVE THIS LINE - FOR AGENCY USE ONLY

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	☐ MALE ☐ FEMALE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )

Are you enrolling a Domestic Partner?(circle one)	**Yes or No**
Is your Domestic Partner: (circle one)	**Pre-Tax or Post-Tax**
Are you enrolling an Older Child(ren) that is neither a full-time student nor a disabled dependent?(circle one)	**Yes or No**
Is your Older Child(ren): (circle one)	**Pre-Tax or Post-Tax**

To qualify a Domestic Partner, you will need to complete and submit the *DOMESTIC PARTNER AFFIDAVIT FORM* (this form must be notarized) and the *DECLARATION OF TAX STATUS FORM* and submit with your enrollment. To qualify as an Older Child (ages 19 to 25 and neither a full-time student nor a disabled dependent), the Older Child must have been covered on an ADOA plan at the age of 18 years old (see the Open Enrollment Guide for qualifications of an Older Child). You will need to complete and submit the *DECLARATION OF TAX STATUS FORM* and submit with your enrollment. These forms can be found on the benefit options website *www.benefitoptions.az.gov*. It is your responsibility, as the employee, to determine whether a dependent is considered a PRE-TAX OR POST-TAX dependent for purposes of determining whether imputed income will apply. Please consult a tax advisor before you certify that your Domestic Partner or Older Child is a PRE-TAX OR POST-TAX dependent. Notice of any change in dependent tax status must be communicated to ADOA within 31 days of the change.

MEDICAL PLANS (Employee Monthly Cost Listed)

☐ **I DECLINE MEDICAL COVERAGE**

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
Counties: Gila, Maricopa, Pima, Pinal, Santa Cruz						
RAN+AMN (HMA) EPO		☐ $30.00		☐ $60.00		☐ $150.00
UnitedHealthcare (UHC) EPO		☐ $30.00		☐ $60.00		☐ $150.00
Arizona Foundation (AZF) PPO		☐ $145.00		☐ $290.00		☐ $415.00
UnitedHealthcare (UHC) PPO		☐ $145.00		☐ $290.00		☐ $415.00
All Other Counties						
RAN+AMN (HMA) EPO		☐ $30.00		☐ $60.00		☐ $150.00
Arizona Foundation (AZF) PPO		☐ $145.00		☐ $290.00		☐ $415.00
OUT-OF-STATE						
Beech Street PPO		☐ $30.00		☐ $60.00		☐ $150.00

DENTAL PLANS (Employee Monthly Cost Listed)

☐ **I DECLINE DENTAL COVERAGE**

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
TOTAL DENTAL ADMINISTRATORS		☐ $5.00		☐ $9.00		☐ $14.00
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		☐ $16.00		☐ $37.00		☐ $63.00

VISION PLAN (Employee Monthly Cost Listed)

☐ **I DECLINE VISION COVERAGE**

SELECT A PLAN	CODE	Tier 1	CODE	Tier 3
AVESIS VISION COVERAGE		☐ $6.34		☐ $17.18

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OPEN ENROLLMENT 2008-2009

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STATE OF ARIZONA ACTIVE OPEN ENROLLMENT 2008-2009 CONTINUED

DEPENDENTS - List all eligible dependents to be enrolled or disenrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)	DATE OF BIRTH (MM/DD/YY)	POST-TAX DEPENDENT	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED	ADD OR DELETE	INDICATE PLAN TYPE MEDICALI(M) DENTAL(D) VISION(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE	**REQUIRED**	**Y OR N**			**Y OR N**	**Y OR N**	**A OR D**	
Employee			S- Spouse C- Child D- Domestic Partner G- Guardian P- Placed for adoption T- Stepchild					
Spouse or Domestic Partner			☐ S ☐ D	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V

SHORT-TERM DISABILITY

The Standard Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay $0.87 for every $100 of your base salary per month. Please see the Open Enrollment Guide for more information regarding Short-Term Disability coverage.

☐ I DECLINE STANDARD SHORT-TERM DISABILITY **☐ I ELECT STANDARD SHORT-TERM DISABILITY**

SUPPLEMENTAL LIFE INSURANCE

Supplemental coverage is available in increments of $5,000. Your cost for Supplemental Life and AD&D insurance is based on your age as of October 1st (the first day of the plan year). Premiums for Supplemental Life coverage above $35,000 are paid on an after-tax basis. You may elect to increase or decrease your Supplemental Life coverage during Open Enrollment. The maximum amount you may elect during Open Enrollment is $20,000. Each year you may increase, in multiples of $5,000, by up to a maximum $20,000. You can decrease in multiples of $5,000 or cancel coverage during Open Enrollment each year. The maximum amount of Supplement Life insurance that you can elect through the State's group plan is three times your annual base salary or $300,000, whichever is less.

☐ I DECLINE SUPPLEMENTAL LIFE INSURANCE	**☐ INCREASE BY $5,000**	**☐ INCREASE BY $15,000**
☐ NO CHANGE ☐ DECREASE BY $_________	**☐ INCREASE BY $10,000**	**☐ INCREASE BY $20,000**

DEPENDENT LIFE INSURANCE

☐ $2,000	**$0.94/MONTH**	**Plan Code 02**	**☐ $12,000**	**$5.64/MONTH**	**Plan Code 12**
☐ $4,000	**$1.88/MONTH**	**Plan Code 04**	**☐ $15,000**	**$7.06/MONTH**	**Plan Code 15**
☐ $6,000	**$2.82/MONTH**	**Plan Code 06**	**☐ I DECLINE DEPENDENT LIFE INSURANCE**		

PRIMARY BENEFICIARY (List additional or Trust information on a separate form which you may obtain from your benefits liaison)

Beneficiary Last Name, First Name	Date of Birth
Beneficiary Street, City, State, Zip Code	Phone No.

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/domestic partner and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In addition, I have read and understand the declarations.

SIGNATURE:____ DATE:______________

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 OR FAX TO:602-542-4744

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